GTL | GUARANTEE TRUST LIFE

ACCIDENT MEDICAL CLAIM FORM

Please read the important information below:

- ❒ Please be sure your Group or Association name is written on the claim form.
- ❒ The claim form must be completed and signed by the Insured Member.
- ❒ The HIPAA Authorization to Permit Use and Disclosure of Health Information must be signed, dated and included with your submission, so that we can contact your medical provider on your behalf if additional information is needed.
- ❒ Attach itemized bills to the claim form. For faster processing, ask your medical provider to print an itemized bill on a UB-04 form (for hospital expenses) or on a CMS 1500/HCFA form (for doctor's expenses).

An itemized bill is a statement that indicates:

1. The date(s) of treatment,
2. The type(s) of service,
3. The diagnosis,
4. The medical provider's name and address,
5. The individual charge for each expense.

• Processing delays may result if you do not provide the above information.

- ❒ Please send the completed claim form, signed authorization, itemized bills and other insurance payment or denial ("Explanation of Benefits") statements to:

Guarantee Trust Life Insurance
P.O. Box 1148
Glenview, Illinois 60025
OR Fax to: (847) 803-1835
OR Email to: AMEClaims@gtlic.com

- Your policy says you must send complete proof of loss (completed and signed claim form and itemized bills) **within 90 days of the accident**. Additional bills related to the accident should be sent within 90 days of treatment.
- Your plan requires treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your Certificate of Insurance for the "Initial Treatment Period."
- If you have other (primary) insurance coverage, please send us a copy of their payment or denial ("Explanation of Benefits") statement.
- Please indicate which bills have been paid by you. If you prefer payment to go directly to the medical provider, please complete and sign the authorization at the bottom of the claim form.
- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group or association name and date of accident.

For assistance, please contact our Customer Service Department (800) 622-1993

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ACCIDENT MEDICAL CLAIM FORM

TO BE COMPLETED BY THE INSURED MEMBER

Group/Association Name or Policy Number Member ID No.

Name of Insured Member Alternate Name Insured Member Date of Birth / /

Address (Street) (City) (State) (Zip Code)

( ) -
Phone Number **Email (Please provide for faster service)**

Patient's/Name and/Relationship *(If other than Insured Member)* Patient Date of Birth / / ❒ Male ❒ Female

Date of Accident / / Time of Accident ❒ AM ❒ PM

Description of Accident: _____

Where did it occur? City: _____ State _____ Location _____

Due to this injury, were or are you currently totally disabled? ❒ Yes ❒ No

Did this accident occur while playing in an Intercollegiate or Professional Sport? ❒ Yes ❒ No

If yes, please indicate the type of sport: _____

Are you self employed? ❒ Yes ❒ No Was this a work related accident/injury? ❒ Yes ❒ No

If yes, was this filed with Workers' Compensation? ❒ Yes ❒ No If no, please explain why: _____

Is the Patient covered by any other plan for expenses related to this accident? ❒ Yes ❒ No

If yes, provide the following information: _____

Insured/Member Name: _____ Insurance Carrier Name _____

( ) - / / / /
Insurance Carrier's Phone Number Policy Number Effective Date Termination Date (if applicable)

I HEREBY AUTHORIZE Guarantee Trust Life Insurance Company to pay bills in connection with this claim directly to the Hospital or Other Medical Provider as indicated below. I understand that I am financially responsible to the Hospital or Other Medical Provider for charges not covered by the policy.

Signature of Insured Date

Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

I understand that this information will be used by Guarantee Trust Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of the authorization upon request.

Insured Member Signature **Print Name** **Date**

Dear Insured: *Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.*

Generic Fraud Warning (to be used for above states only) Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island and West Virginia – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California – For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – A person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland – Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico – ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio and Oregon – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington State – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Texas – Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Washington DC – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Guarantee Trust Life Insurance Company
P.O Box 1148, Glenview, Illinois 60025
1-800-622-1993

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

(Print Please) Name of Patient _____ Date of Birth _____

Signature of Patient _____ Date _____

(Please Print) Name of Authorized Representative, or Next of Kin _____

Relationship of Authorized Representative or Next of Kin to Patient _____

Signature of Authorized Representative or Next of Kin _____ Date _____